

New Jersey Department of Health and Senior Services
Senior Gold Prescription Discount Program
PO Box 724
Trenton NJ 08625-0724

Senior Gold Prescription Discount Program
Eligibility Application

Please PRINT clearly and answer all questions. See instructions on last page.
 If you need assistance completing this form, call toll free 1-800-792-9745.

DO NOT SUBMIT ORIGINAL SUPPORTING DOCUMENTS, SEND COPIES, AS ORIGINALS WILL NOT BE RETURNED.
 Mail the completed application to the address listed above.

Please check who is applying for Senior Gold: ☐ **Applicant** ☐ **Spouse** ☐ **Both**

Important Notice to Married Applicants: ALL Information MUST be provided
for both husband and wife even if only one is applying for assistance.

1	Last Name of Applicant		Maiden Name		First Name		MI	Sex	Date of Birth ____/____/____ (Month/Day/Year)
	Last Name of Spouse		Maiden Name		First Name		MI	Sex	Date of Birth ____/____/____ (Month/Day/Year)
2	Street Address				City		State		Zip Code
	How long have you lived at this address? (see instruction #2) ____ Years ____ Months						Is this your principal place of residence? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	One (1) proof of residency for EACH must accompany this application. (If using a post office box, send proof of your actual street address.)								
3	Applicant's Social Security Number ____-____-____					Spouse's Social Security Number ____-____-____			
	Do you have Medicare A (Hospital Insurance)? Applicant <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No					Do you have Medicare B (Medical Insurance)? Applicant <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Applicant's Medicare Number: _____					Part B Effective Date: ____/____/____ MM/YY			
	Spouse's Medicare Number: _____					Part B Effective Date: ____/____/____ MM/YY			
Please enclose a copy of your Medicare card(s).									
4	TO BE ELIGIBLE, YOU MUST BE AGE 65 OR OLDER OR RECEIVE SOCIAL SECURITY DISABILITY BENEFITS. Documents must accompany this application. See instruction #4.								
	a. Are you 65 years of age or older?		Applicant		<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes is answered to any question in Section 4a or 4b, submit proof of age and/or disability.		
			Spouse		<input type="checkbox"/> No	<input type="checkbox"/> Yes			
	b. Are you under age 65 and over age 18 and do you receive Social Security Disability?		Applicant		<input type="checkbox"/> No	<input type="checkbox"/> Yes			
		Spouse		<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Is your spouse already enrolled in the Senior Gold Program? <input type="checkbox"/> No <input type="checkbox"/> Yes									
If Yes, list ID Number: _____									
5	Did you and/or your spouse file a federal, state or city income tax return last year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, you must submit signed copies of each return, including all schedules, with this application.								
6	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced					Has your marital status changed in the last year? <input type="checkbox"/> Yes - Date ____/____/____ <input type="checkbox"/> No			

7	List <u>MONTHLY</u> amount of most recently received Social Security check: <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 33%; text-align: center;">Applicant Alone</td> <td style="width: 33%; text-align: center;">Spouse Alone</td> <td style="width: 33%; text-align: center;">Joint (applicant and spouse)</td> </tr> <tr> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> </tr> </table>						Applicant Alone	Spouse Alone	Joint (applicant and spouse)	\$ _____	\$ _____	\$ _____						
Applicant Alone	Spouse Alone	Joint (applicant and spouse)																
\$ _____	\$ _____	\$ _____																
8	Sources of Income List all income received for the previous calendar year, as well as all income anticipated for the current calendar year. Section A is for actual income (previous year). Section B is for anticipated income (current year). SEE INSTRUCTION #8. DO NOT LEAVE ANY BLANKS. If you receive None, write "O" in the appropriate space. Please be sure to total each column. Do not list cents.																	
	All Sources of Income List <u>Yearly</u> Amounts <i>(If more space is required, attach an additional sheet.)</i>	Section A Income Previous Year (Actual) 2002		Section B Income current year (Anticipated) 2003		For Office Use Only (DO NOT WRITE BELOW)												
		Applicant	Spouse	Applicant	Spouse													
	a. Social Security Benefits (Net)																	
	b. Medicare Part B Premium (See Instruction #8)																	
	c. Pension Benefits (Gross)																	
	d. Salary Before Payroll Deductions (Gross)																	
	e. Unemployment Benefits																	
	f. Interest and Dividends (Including Tax Exempt)																	
	g. Rental Income (Net After Expenses)																	
	h. All Other (Identify)																	
	TOTAL ANNUAL INCOME (BY COLUMN)																	
9	Do you and/or your spouse receive a pension and/or salary? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please identify the company, employer, or union:																	
	Name of Company, Employer or Union				Telephone Number ()													
	Street or PO Box																	
	City, State, Zip Code																	
10	Do you have health coverage in addition to Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If this coverage is provided through an employer group, please identify the employer or union:			For Office Use Only Applicant Spouse <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>														
	Name of Employer or Union																	
	Street or PO Box																	
	City, State, Zip Code																	

11	Health Insurance Coverage If you and/or your spouse currently have health insurance coverage (with or without prescription benefits) with any insurance company, complete this section. A photocopy of the front and back of your health insurance card(s) must be attached to your application. You will still be considered for enrollment in the Senior Gold program if you have prescription coverage through another health insurance plan.	
	Are you a member of a Medicare HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of HMO: _____ Is your spouse a member of a Medicare HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of HMO: _____ If you have more than one (1) health insurance carrier, provide information for all of them. Use a separate page if necessary.	
	1) Name of Insurance Carrier:	2) Name of Insurance Carrier (if you have more than one):
	Address of Insurance Carrier: _____ _____	Address of Insurance Carrier: _____ _____
	ID # _____ Policy Group # _____	ID # _____ Policy Group # _____
	Telephone Number of Insurance Carrier: ()	Telephone Number of Insurance Carrier ()
	Does your insurance pay for prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your insurance pay for prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Does this plan have a separate deductible amount for prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the deductible amount? \$ _____	Does this plan have a separate deductible amount for prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the deductible amount? \$ _____
	Please indicate if the above health insurance is: #1 <input type="checkbox"/> HMO <input type="checkbox"/> Major Medical Plan <input type="checkbox"/> Supplement to Medicare <input type="checkbox"/> Other _____ #2 <input type="checkbox"/> HMO <input type="checkbox"/> Major Medical Plan <input type="checkbox"/> Supplement to Medicare <input type="checkbox"/> Other _____	
	Remember to include a photocopy of the front AND back of your insurance card(s).	
12	A. I/we certify that the information above is true and accurate to the best of my/our knowledge and that I/we meet all Program eligibility requirements. B. I/we will return my/our eligibility card(s) immediately if my/our income rises above the legal limits, or if I/we move from New Jersey, or if I/we become New Jersey Care or Medicaid eligible. If I/we are determined eligible based on my/our disability(ies), I/we will return my/our eligibility card(s) if I/we stop receiving Social Security Disability Benefits. C. I/we authorize the release of information necessary to determine my/our eligibility from the records in possession of the Social Security Administration, Internal Revenue Service, the New Jersey Division of Taxation, Division of Medical Assistance and Health Services, employers, banks, utility companies and others as the need arises. I/we authorize my/our physician(s) to release information concerning prescriptions which have been paid on my/our behalf by the Program. D. I/we understand that I/we may be visited by representatives of the Department of Health and Senior Services in order to verify my/our eligibility for benefits and determine availability of other prescription coverage and I/we authorize such visitations. E. I/we hereby assign the State of New Jersey any right to drug benefits to which I/we may be entitled under any other plan of assistance or insurance or from any other liable third party. F. I/we understand that the Department of Health and Senior Services is entitled to full repayment for incorrectly provided benefits. I/WE FURTHER UNDERSTAND THAT IF I/WE LOSE ELIGIBILITY BECAUSE OF AN INCREASE IN ANNUAL INCOME, I/WE ARE LIABLE FOR REPAYMENT OF ALL MONIES PAID ON MY/OUR BEHALF BY THE STATE OF NEW JERSEY FROM THE BEGINNING OF THE CALENDAR YEAR, NOT JUST THOSE PAYMENTS MADE AFTER MY/OUR INCOME INCREASED AND EXCEEDED THE ELIGIBILITY LIMITS, AND THAT FAILURE TO REPAY BENEFITS INCORRECTLY PROVIDE ON MY/OUR BEHALF IS CONSIDERED A VIOLATION OF STATE LAW AND WILL SUBJECT ME/US TO SUSPENSION OF BENEFITS IN THE FUTURE. G. I/we understand that the use of my/our eligibility card(s) and the receipt of benefits in any calendar year certifies and confirms my/our agreement to accept full liability for repayment of all benefits incorrectly received in that year.	
	Signature or Mark of Applicant	Telephone Number ()
	Signature or Mark of Spouse (If Married)	Date
	Person to Contact if Questions Arise	Telephone Number ()
	Signature of Preparer	Date

**INSTRUCTIONS FOR COMPLETING
Senior Gold Prescription Discount Program
Eligibility Application**

**Please note that EACH person MUST submit age, residence and/or disability documentation
for EACH individual applying for Senior Gold.**

Joint income (of applicant and spouse) is considered in determining eligibility.
The following instructions are numerically keyed to the various sections of the form.

SECTION 2

Enter your principal place of residence. Proof of residence must accompany the application. The proof must be current and dated. The date must be clearly visible and within the last six (6) months. The residence requirement states that you must be a resident of the State of New Jersey for at least 30 days prior to the date of your application.

Some examples of sources of residence are:

- | | | |
|---|--|--|
| ➤ Public utility records and receipts
(e.g. telephone bill, electric bill, etc.) | ➤ Bills of business or professional people
(e.g. doctors, pharmacies, etc.) | ➤ Post Office records |
| ➤ Social Security records (e.g. Third Party
Query, SSA Form 2458, etc). | ➤ Motor Vehicle Records
(e.g. Valid Driver's License) | ➤ Records of social agencies, public
or private |

Note: Seasonal or temporary residence in New Jersey, of whatever duration, does NOT constitute residence.

SECTION 3

You are not required to submit your Social Security number, however, failure to provide one will delay the processing of your application. Your Social Security number will be used to create a unique identifier to track your application, to provide and record pharmaceutical benefits, to verify eligibility by matching tax files at the New Jersey Division of Taxation, and to identify other prescription coverage by searching health insurance records.

SECTION 4

a) If you are 65 years of age or older, submit a COPY of one of the following documents:

- | | |
|-------------------------|---|
| ➤ Birth Certificate | ➤ Railroad retirement Letter |
| ➤ Baptismal Certificate | ➤ Any Social Security record which indicates your age |

IF YOU CANNOT SUPPLY A COPY OF ONE OF THE ABOVE DOCUMENTS, COPIES OF ANY TWO OF THE FOLLOWING DOCUMENTS WHICH INDICATE AGE WILL BE ACCEPTABLE.

- | | | |
|--------------------|----------------------------------|-------------------|
| ➤ Driver's License | ➤ State or Federal Census record | ➤ Voting record |
| ➤ Foreign Passport | ➤ Your Child's Birth Certificate | ➤ Marriage Record |
| ➤ School Record | ➤ Insurance Policy | |

b) If you are UNDER 65 years of age and over 18 years of age and receive Social Security Title II Disability Benefits, submit a COPY of one of the following documents:

- Social Security Award Certification (SSA-L30) issued by the Social Security Administration within the last six months
- Verification of your disability status by your local Social Security Office through the "Report of Confidential Social Security Beneficiary Information" (SSA-2458) or Third Party Query Form which indicates your current Social Security Disability status.

SECTION 7

Indicate the exact amount of the most recently received Social Security check(s). If separate checks are received, list your and your spouse's checks separately. If a joint check is received, indicate total amount.

SECTION 8

Examples of other income which must be included under "ALL OTHER" income (Line h) are:

- | | | |
|--|---------------------------------|--------------------------------------|
| ➤ Gross IRA (incl. Roth distributions) | ➤ Realized Capital Gains | ➤ Inheritance |
| ➤ Gross Disability Benefits | ➤ Alimony Payment | ➤ Gross Gambling or Lottery Winnings |
| ➤ Royalties | ➤ Death Benefits Received (Net) | ➤ Business Income (Net) |
| ➤ Gross Retirement benefits/Annuities | | |

Jointly earned income should be allocated to your and your spouse's share of ownership.

*The annual Medicare Part B premium must be included as income on Line b of Section 8 if you and/or your spouse have this premium deducted monthly from your Social Security check. NOTE: The monthly deduction should be multiplied by twelve (12) to get the yearly amount. Most individuals who receive Disability payments or who are over age 65 have Medicare Part B deducted from their Social Security check.

As of January 1, 2003, income limits are at least \$20,016 and less than \$30,016 if single; at least \$24,542 and less than \$34,542 joint income, if married. If your income exceeds these limits, DO NOT APPLY.

SECTION 11

If you and/or your spouse have any health insurance coverage, complete section 11 and submit a copy of the front and back of all insurance card(s).

SECTION 12

The Certification and Authorization must be dated and signed (or marked) by you, your spouse (if married) and the preparer of the form (if other than the applicant). Anyone other than the applicant who prepares the form must provide his/her name and telephone number, in case questions should arise concerning the application.